



FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

FCP/142120

PRELIMINARY RECITALS

Pursuant to a petition filed July 02, 2012, under Wis. Admin. Code § DHS 10.55, to review a decision by the Care Wisconsin in regard to Medical Assistance, a hearing was held on February 05, 2013, at Waukesha, Wisconsin.

The issue for determination is whether the agency properly denied the Petitioner's request for 10 additional one way transportation tickets.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street
Madison, Wisconsin 53703
By: Carmen Lord
Care Wisconsin
2802 International Lane
Madison, WI 53704

ADMINISTRATIVE LAW JUDGE:

Debra Bursinger
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Waukesha County.
2. The Petitioner has been enrolled in FC since August 1, 2008 at a nursing home level of care in the FC program since August 1, 2008. He meets the Physical Disability and Developmental Disability target groups.

3. The Petitioner has diagnoses that include a hormonal/metabolic system disorder, osteoarthritis in his feet and back, sleep apnea, diabetes type II, hypertension and severe obesity. He wears a brace on his left foot. The Petitioner is also diagnosed with a depressive disorder and Pervasive Developmental Disorder NOS as well as mild cognitive/learning disabilities.
4. The Petitioner's Member Centered Plan includes the following outcomes and the ways those outcomes are being met:

“I want to socialize with others in the community.” Petitioner attends Friendship House and music therapy. He also attends church services and goes to the library on occasion. He goes on family outings occasionally. The Petitioner utilizes formal and informal supports for these activities.

“I want to continue doing activities I enjoy, using my talents and following my passions.” Petitioner attends music therapy once/week. He visits with peers at Friendship House. He attends church services and goes to the library on occasion. He goes on family outings occasionally. The Petitioner utilizes formal and informal supports for these activities.

“To maintain and improve overall health.” Petitioner attends the YMCA for exercise. The YMCA has a pool that he is able to use. He has access to local parks.
5. On May 18, 2012, the Petitioner requested a YMCA membership to be included in his Family Care plan at a cost of \$33/month. In addition, the Petitioner requested 10 additional one-way transportation tickets to allow him to get to the YMCA.
6. On June 12, 2012, the agency issued a Notice of Action to the Petitioner informing him that the request for a YMCA membership was denied because his outcome is being supported in other ways.
7. On July 2, 2012, an appeal was filed on the Petitioner's behalf with the Division of Hearings and Appeals.

DISCUSSION

The Petitioner receives Family Care Medical Assistance benefits through Care Wisconsin. This health-service delivery system is authorized by a medical assistance waiver under 42 USC 1315 and is designed to increase the ability of the frail elderly and those under 65 with disabilities to live where they want, participate in community life, and make decisions regarding their own care. Family Care recipients are placed under the roof of a single private provider, called a care maintenance organization (CMO), that receives a uniform fee, called a capitation rate, for each person it serves. The CMO is responsible for ensuring that the person receives all the Medicaid and Medicare services available to him. The theory behind the program is that it will save money by providing recipients with only the services they need rather than requiring that they enroll in several programs whose services may overlap.

Each CMO signs a contract with the State of Wisconsin that sets forth exactly what services it must render. Care Wisconsin's contract requires it to provide services to physically and developmentally disabled adults and frail elders who are financially eligible for medical assistance and “[f]unctionally eligible as determined via the Long-term Care Functional Screen...” Contract Between Department of Health and Family Services and Care Wisconsin. Once a person is found eligible for the Family Care Program, Wisconsin law requires the CMO to assess her needs and create an individual service plan that meets those needs and values. This plan must provide services and support at least equal to those he

would receive under the Wisconsin Medical Assistance Program and the various MA Waivers program. It can provide additional services that substitute for and augment these services if they are cost effective and meet his needs. Wis. Admin. Code, § DHS 10.41(2).

When determining whether medical assistance regulations require the CMO to provide a specific service, the CMO must consider, among other things, the medical necessity of the service, the appropriateness of the service, the cost of the service, the extent to which less expensive alternative services are available, and whether the service is an effective and appropriate use of available services. Wis. Adm. Code § DHS 107.02(3)(e)1.,2.,3.,6. and 7. “Medically necessary” means a medical assistance service under ch. DHS 107 that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
 2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
 3. Is appropriate with regard to generally accepted standards of medical practice;
 4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
 5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
 6. Is not duplicative with respect to other services being provided to the recipient;
 7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;
 8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
 9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

The skeletal legal guidance that pertains to determining the type and quantity of daily care services that must be placed in an individualized service plan (ISP) is as follows:

DHS 10.44 Standards for performance by CMOs.

...

(2) CASE MANAGEMENT STANDARDS. The CMO shall provide case management services that meet all of the following standards:

...

(f) The CMO, in partnership with the enrollee, shall develop an individual service plan for each enrollee, with the full participation of the enrollee and any family members or other representatives that the enrollee wishes to participate. ... The service plan shall meet all of the following conditions:

1. Reasonably and effectively addresses all of the long-term care needs and utilizes all enrollee strengths and informal supports identified in the comprehensive assessment under par. (e)1.
2. Reasonably and effectively addresses all of the enrollee's long-term care outcomes identified in the comprehensive assessment under par. (e)2 and assists the enrollee to be as self-reliant and autonomous as possible and desired by the enrollee.
3. Is cost-effective compared to alternative services or supports that could meet the same needs and achieve similar outcomes.

...

Wis. Admin. Code §DHS 10.44(2)(f).

The agency argues that it already provides 30 one-way tickets (15 round trip) per month to the Petitioner to assist him with meeting his community integration outcome. It further notes that the Petitioner's household includes two adults in the home that do not work. Therefore, the Petitioner's transportation needs are being met.

The Petitioner's mother testified that the request for additional trip tickets is related to the Petitioner's need to attend the YMCA to meet the outcome related to improving overall health. She testified that she and her husband are on a fixed income and it is therefore difficult to transport him to the YMCA. They are already transporting him to and from numerous doctor appointments each month.

Based on the evidence presented, I conclude that the requested trip tickets are necessary in order for the Petitioner to achieve his outcome of improving overall health by attending the YMCA. I conclude that 5 round trips/month to the YMCA is reasonable to address the Petitioner's outcome.

CONCLUSIONS OF LAW

The agency did not properly deny the Petitioner's request for 5 round trip tickets/month to go to the YMCA.

THEREFORE, it is

ORDERED

That this matter is remanded to the agency to take all administrative steps necessary to rescind its denial of June 12, 2012 and to pay for or reimburse the Petitioner for the cost of 5 round trip tickets/month to attend the YMCA retroactive to the date of the request on May 18, 2012. These actions shall be taken within 10 days of the date of this decision.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

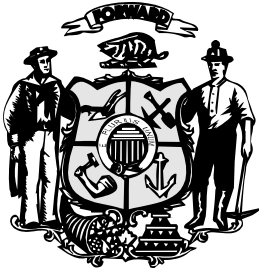
You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 25th day of March, 2013

\sDebra Bursinger
Administrative Law Judge
Division of Hearings and Appeals



State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on March 25, 2013.

Care Wisconsin
Office of Family Care Expansion